## **Consent to Release Insurance Information**

| Patient Name  |
|---|
|   |
| Date of Birth   |
|   |
| Address   |
|   |
| Phone Number  |
|   |
| Insurance Information   |
| Insurance Company Name  |
|   |
| Policy Number   |
|   |
| Group Number  |
|   |
| Consent   |
| I hereby give consent to release my insurance information for the purposes of processing claims and verifying eligibility and benefits: |
|   |
| ☐ I understand and agree to the release of my insurance information as described above.  Signature                                      |
|   |
| Date  |
|   |
|   |